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## Southern Regional Health Consortium

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### Promoting Access to Health in an Eight-State Southern Region

*The Southern Regional Health Consortium is dedicated to considering not just access to health care, but access to health itself for a part of the population that persistently lags behind.*

*If we can understand how underlying social factors create barriers to health, perhaps we can design interventions that will broadly and significantly improve health outcomes and, further, will improve health equity across populations.*

*These root causes cannot be ignored; collectively, they are the key to a positive health future.*

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The Southern Regional Health Consortium (SRHC) is working to build the long-term infrastructure and leadership needed to improve health status in some of the most rural and medically underserved states in the country. An outgrowth of the Southern Rural Access Program launched in 1997 by the Robert Wood Johnson Foundation, SRHC comprises key public health stakeholders from Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, East Texas and West Virginia.

For the first seven years, the stakeholders focused on traditional access to care - developing leadership; recruiting and retaining providers; building rural health networks; and establishing revolving loan programs for capital financing. Despite considerable achievements, the group concluded that improving access to healthcare alone would not close the region’s acute health gap. It began to reshape its efforts according to an evolved definition of access as access to the necessary ingredients for health itself, asking: *What barriers stand between southern populations and health? How can we remove those barriers to enable our residents to flourish in mind, body, and spirit?*



## Health Status

The eight SRHC states possess some of the poorest health status in the country: SRHC encompasses 7 of the bottom eight positions in the United Health Foundation’s 2004 State Health Rankings (*Figure 1*); and only 75% of SRHC adults deem their health “good” or “excellent” as compared with 85% nationwide. SRHC states show pronounced prevalence on many specific poor-health indicators, including diabetes, hypertension, infant mortality and cancer mortality, for example (*Figure 2*).

*Figure 1: The SRHC states rank among the lowest in the country on a composite health score.*

State	2004 Rank (1-50)
Minnesota	1
New Hampshire	2
Vermont	3
Hawaii	4
Utah	5
...	...
Texas	35
...	...
Alabama	43
West Virginia	43
Georgia	45
Arkansas	46
South Carolina	47
Tennessee	48
Mississippi	49
Louisiana	50

## Acknowledgements

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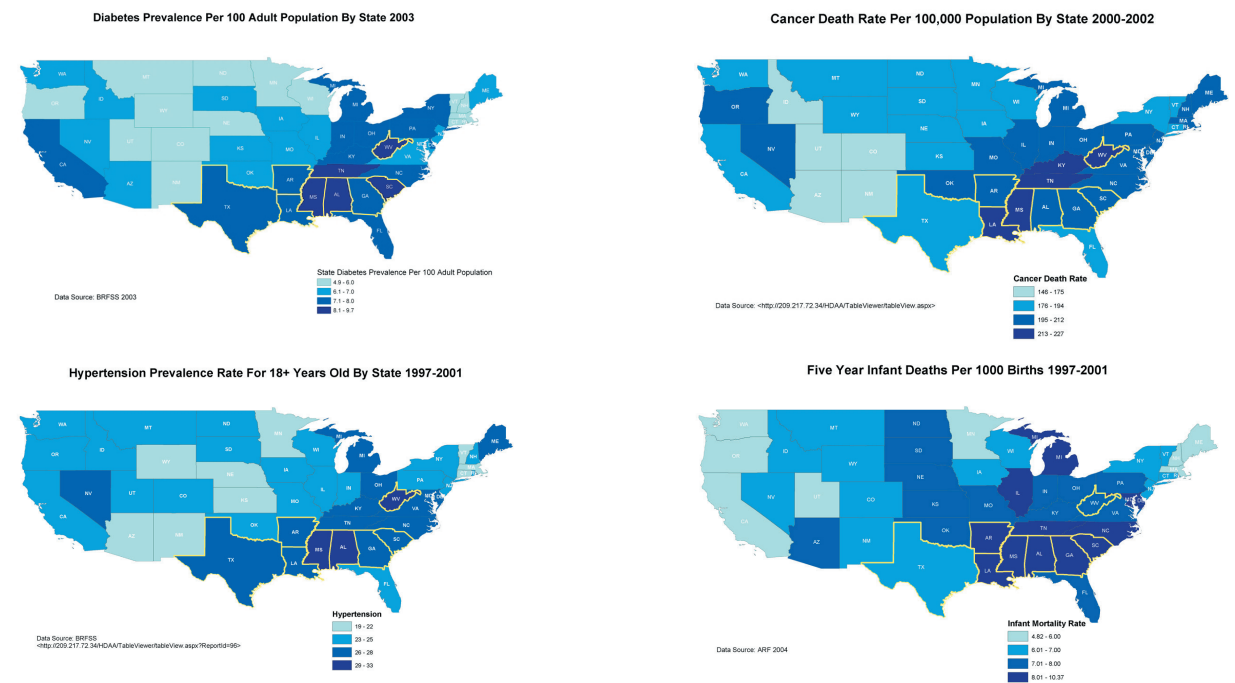


## Conclusion

*What makes socioeconomic position such a powerful determinant of health is that it shapes people’s experience of, and exposure to, virtually all psychosocial and environmental risk factors of health –past, present, and future – and these in turn operate through a very broad range of physiological mechanisms to influence the incidence and course of virtually all major causes of disease and health... Socioeconomic position is a “fundamental cause” of levels of individual and population health and a fundamental lever for improving health in American society.* -- Williams & House, 1997 in Health and Social Justice, ed. Hofrichter

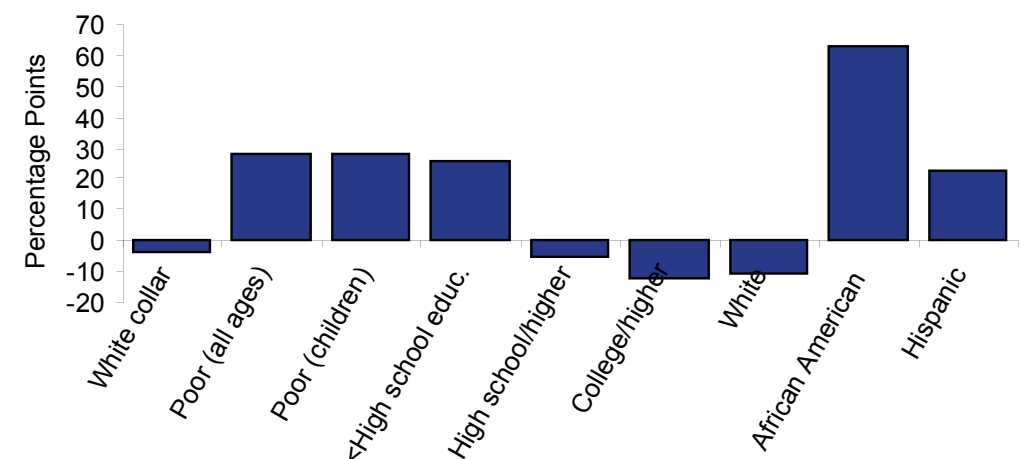
The Southern Regional Health Consortium is dedicated to considering not just access to health care, but access to health itself for a part of the population that persistently lags behind. If we can understand how underlying social factors create barriers to health, perhaps we can design interventions that will broadly and significantly improve health outcomes and, further, will improve health equity across populations. These root causes cannot be ignored; they are the key to a positive health future.

*Figure 2: The SRHC states, outlined in gold, show pronounced prevalence on many specific poor-health indicators, including diabetes, hypertension, cancer deaths, and infant mortality, shown here.*



The SRHC states also exceed national rates for recognized root causes of health disparities among sub-populations: lower occupational status, higher poverty, lower educational attainment, and higher proportions of African Americans and Hispanics (*Figure 3*). SRHC examines how these factors result in poor health in order to identify interventions at the root level where there is the greatest leverage and promise for broad, lasting improvement.

*Figure 3: SRHC states have high proportions of populations at risk of poor health and low proportions of those who are more likely to be healthy. The figure below shows the difference between SRHC per capita population and the national average (Area Resource File 2004).*





## Access to Health

Health, the functioning of physical, emotional, and psychological systems, is a normative state for the human organism. That is, for most people, in the absence of inadequate or harmful inputs to the system, it operates within a range that would lead them to deem their health good or better. This is confirmed by the self-reported “good” or “excellent” health of 85% of US adults in the 2003 Behavioral Risk Factor Surveillance Survey (BRFSS).

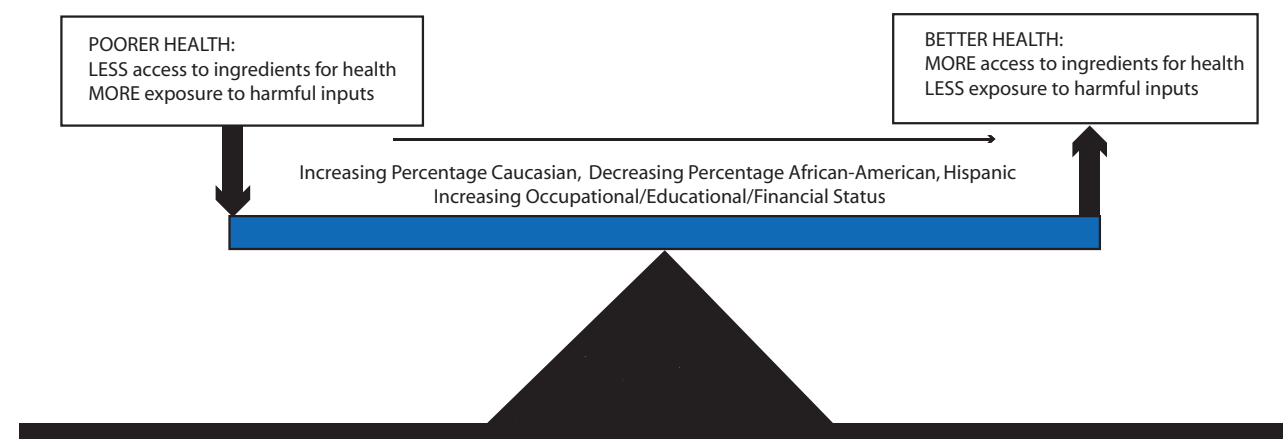
The ingredients needed for health are well known: they include food, water, oxygen, physical activity, rest, sleep, intellectual stimulation and social connectedness, as well as preventive and remedial health care. Health is undercut by inadequate supplies of these ingredients, or is actively thwarted by harmful inputs such as hazardous components in food, air or water; assaults to physical integrity; psychologically stressful circumstances or damaging social interactions.



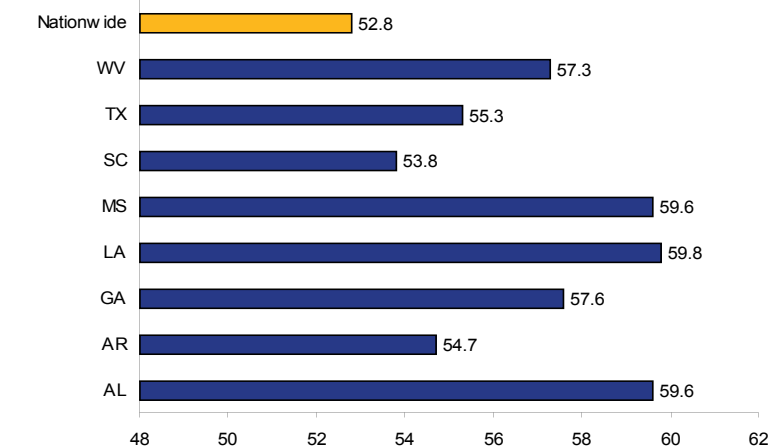
## Social Determinants of Health

It follows that a population’s access to health is determined by the degree to which it can access the basic ingredients for health and the degree to which it is exposed to harmful inputs. Thus, if social factors are at the root of observed health disparities, as many researchers have demonstrated, then they must differentially affect populations’ access to the ingredients for health and exposure to harmful inputs (*Figure 4*). What follows are definitions of key social factors considered root causes of health disparities; a description of how they interact as a social system; and an explanation of potential pathways from root causes to specific health outcomes (*Figure 5*).

*Figure 4: A population’s access to health is determined by the degree to which it can access the basic constituents for health and the degree to which it is exposed to harmful inputs. This figure shows how social factors result in health disparities.*



*Figure 7: Compared to the national per capita average, a higher proportion of SRHC residents fail to meet recommended guidelines for moderate physical activity (BRFSS 2003). Physical inactivity is an important contributor to diabetes and hypertension, among other poor health outcomes.*



To trace just one root cause (financial capacity) through one component cause (physical inactivity) to its impact on one health indicator (diabetes), we see that

- Lower financial capacity (influenced in turn by education, occupation, race, gender, ability, etc.) creates an array of obstacles to adequate physical activity for poorer populations - less access to safe places to walk, jog, or play; less access to recreational facilities; less available time for leisure, etc.
- These obstacles to adequate levels of physical activity (particularly when coupled with obstacles to appropriate dietary practices) result in caloric imbalances that produce higher obesity rates.
- Higher obesity rates result in higher incidence of diabetes.
- Thus, not only is diabetes more prevalent in populations with lower financial capacity; in fact, low financial capacity is a root cause of diabetes (CDC, National Health Interview Survey 2003).



Importantly, social status is also determined by an array of other, immutable characteristics reflecting the dominant culture’s general favor or disfavor. These include race/ethnicity, sex/gender, age, ability, sexual orientation, religious affiliation, national origin, citizenship/documentation status, and others. For example, in the U.S., women earn 23% less than men (US Census Bureau, Current Population Survey Annual Social and Economic Supplement, 2005); African Americans are 37% less likely to hold a bachelor’s degree than Caucasians (U.S. Census Bureau, Current Population Survey, 2004); and disabled adults are 25% less likely to be employed than adults without disabilities (US Census, 2000).

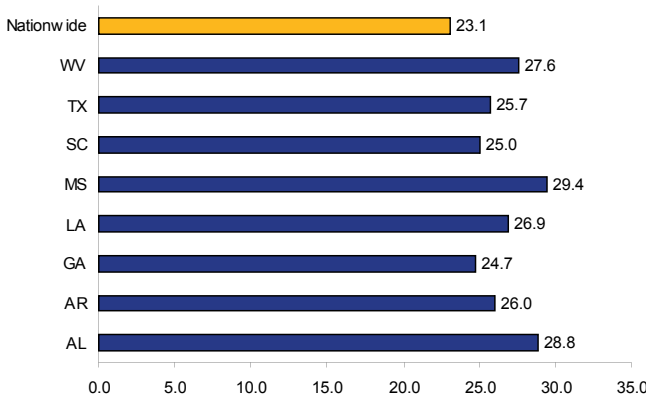
Apart from the sizable influence of race, sex, education, occupation, and financial capacity, there are a number of direct pathways from these social status factors to health access. For example, they determine exposure to marketing of unhealthy products (e.g. courting of children by fast-food companies through toys, playgrounds and TV ads); bias-based stresses and violence (e.g. domestic violence and hate crimes); and environmental hazards (e.g. air pollution: Ash and Fetter, U. Mass. 2002, and lead: CDC, MMWR, 2003).



## Pathways From Social Determinants to Health Outcomes

For the health indicators presented at the outset -- diabetes, hypertension, cancer mortality, infant mortality -- some of the key component causes are obesity, physical inactivity, smoking, lack of preventive care, and inadequate health care. Most or all of the SRHC states exceed national rates for each of these component causes, according to BRFSS data - [\(Figures 6-7\)](#). [Figure 5](#) suggests numerous pathways through which social factors may act as root causes of positive or negative outcomes, calling particular attention to some of the pathways relevant to the indicators and component causes mentioned here.

*Figure 6: Obesity is a component of poor health outcomes, including diabetes and hypertension. All eight SRHC states exceed national obesity rates, based upon BRFSS Body Mass Index data 2004.*



**Education** encompasses the quality, degree, and prestige of formal education and training acquired. Have you completed the 9th grade, or a post-graduate degree? Did you go to a highly effective school or one in which it was difficult to focus on academic learning? How is the school you last attended regarded in your community or profession? Education strongly influences occupation and financial capacity: those with further or more prestigious educations have better job options, are more upwardly mobile, and command higher pay for the same work than those with less or poorer education. Apart from its influence on health through these other factors, education’s direct pathways to health include the acquisition of health knowledge, critical thinking skills, and socialization to adopt health-promoting or health-negating behaviors.

**Occupation** means the skill and responsibility level of employment attainable, and the security, options and mobility of employment. Do you have a job, or are you unemployed? Are you in high demand as a worker or are you in a low-skill, low-responsibility position? Do you have multiple, good options for employment, and opportunities for advancement; could you lose your job at any time? Occupation significantly affects financial capacity: the better the job, the better the pay and the more apt to promote wealth generation through salary, job growth and employee benefits. But occupation also affects education in the form of continuing education, employee training, and other educational incentives or benefits that come with better jobs. In addition to its effects through these companion factors, occupation itself impacts health through such pathways as on-the-job health screening and information; psychological, emotional or physical hazards; and dining options and culture.

**Financial capacity** includes the level and reliability of income and assets at one’s disposal. What level of wage do you earn? Can you live on it? Are you able to save? Do (or might) your income or assets fluctuate widely? Do you have inherited wealth; own your own home; have a retirement plan? Financial capacity has a strong effect on education, especially in successive generations. That is, the more money parents have at their disposal, the better the educational prospects of their children. But it works within generations as well: those with greater incomes and/or accumulated assets can acquire more education and advance even further in their careers. Financial capacity affects occupation in the sense that greater financial stability affords wider options for employment - one can wait for the right job, or move to a different location for a job, for example. Financial capacity has numerous pathways to health outcomes, as it determines the ability to afford health-promoting diet, recreation, living conditions, health care, and other necessary ingredients.

**Social status** refers to the degree of power and privilege held, in relation to that of others in society. How much influence do you have on institutions, organizations, people, and political systems that affect you? Do doors swing open effortlessly for you, or close in your face? Do you experience prejudice, hostility or even violence due to biases in the dominant culture or the legacy of such biases? Social status (within and across generations) strongly affects each of the above three factors. People of higher social status are more likely to get prestigious educations, acquire better jobs, command higher pay, and inherit wealth than those of lower social status. Reciprocally, social status also is determined by the other three factors: Higher education, prestigious employment, higher disposable income, and accumulated wealth confer higher social status. Thus, this social system is self-reinforcing and self-perpetuating.

Figure 5:

Key to Selected  
Component Causes of  
Poor Health

(H) = Health Care

(O)= Obesity

(I) = Physical Inactivity

(S) = Smoking

(P) = Prevention/Screening

Social Status (privilege and power) determines

- Exposure to bias-based stress or violence
- Exposure to environmental hazards
- Exposure to marketing of unhealthy behaviors (O, S)
- Ability to influence social/political systems to meet needs/solve problems (O, I, H)
- Sense of security, autonomy, optimism (H)
- Quality, degree and appropriateness of health care (H)

- Healthy food (O)
- Recreational opportunities (I)
- Reliable health information (O, S, I, P)
- Preventive care (P)
- Treatment (H)
- Health insurance (H)
- Leisure activities (I)
- Safe child care
- Transportation (O, P, I, H)
- Flexibility and options to cope with stressors, setbacks
- Sense of security, power, choices (P, H)

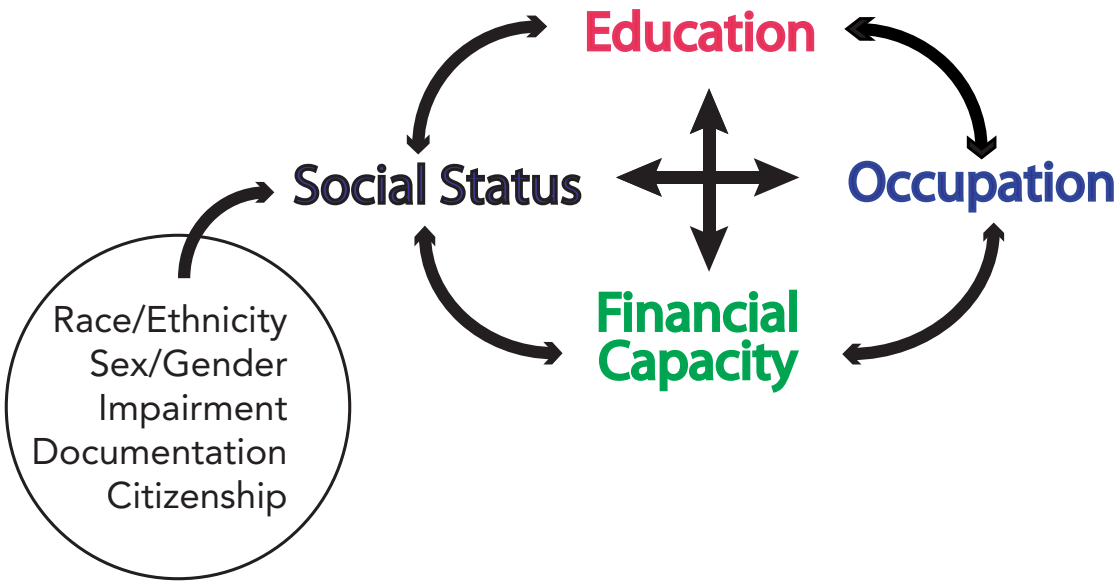
- Time for
  - o Purchasing and preparing healthful food (O)
  - o Physical activity (I)
  - o Leisure activities (I)
  - o Family nurturance (structure, organization, reading to children)
  - o Preventive care (P)
  - o Treatment

Social Determinants of Health:

The Social System and Pathways Providing Access or Barriers to Health

Education (level, quality, prestige) determines

- Knowledge base (O, I, S, P, H)
- Critical thinking skills/ability to process information (O, I, S, P, H)
- Social skills (ability to interact with institutions and health practitioners) (P, H)
- Socialization to adopt health-promoting behaviors (O, I, S, P, H)
- Sense of autonomy, capability and options (P, H)



Financial Capacity (income and assets) determines the attainment of

- A home with
  - o Safe, effective climate control
  - o Books, computer, internet
  - o A degree of order, cleanliness
  - o Amenities (e.g. laundry)
- A home without
  - o Construction hazards
  - o Toxins, mold, mildew, pests
  - o Overcrowding
- A home in an area with
  - o Good social cohesion
  - o Low crime rate (I)
  - o Good infrastructure (communications, utilities, transportation, law enforcement) (I)
  - o Minimal pollution (air, water, surface, noise) (I)
  - o Quality, safe, accessible schools and child care
  - o Safe, accessible recreational opportunities (I)
  - o Access to affordable, healthful food (O)
  - o Access to good employment
  - o Access to leisure activities (I)